Anna J. Thomas, MPH
Public Health Director

Philip J. Alexakos, MPH, REHS
Chief Operations Officer

Jaime L. Hoebeke, MPH, MCHES
Chief Strategy Officer

CITY OF MANCHESTER

Health Department

MEDICATION OR PROCEDURE ORDER FORM

STUDENT NAME: _____ D.O.B. _____

This form must be **signed by a physician *and* a parent or guardian**. This includes prescription and non-prescription (over-the-counter) medications that will be taken during the school day.

To Be Completed by the Healthcare Provider

DIAGNOSIS: _____

MEDICATION/PROCEDURE:

_____

_____

DOSAGE: _____ ROUTE: _____

TIME OF ADMINISTRATION: _____

_____

SPECIAL INSTRUCTIONS (Optional):

_____

PRESCRIBED BY: _____ DATE: _____
(Signature of Health Care Provider)

Print name: _____ Providers Phone #: _____

PARENT / GUARDIAN PERMISSION *(Required Before Administration)*
I hereby authorize the designated staff person to administer the above-prescribed medication/procedure according to the directions. In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, the City of Manchester and/or any department or employee thereof for any death or injury resulting from the administration or assistance in the administration of the medication described above.

In the occasion of a field trip, ☐ **I DO** ☐ **I DO NOT** wish to have my child's medication administered by the following designated staff person, _____.

Signature of Parent/Guardian: _____ **Date:** _____

Optional Release: I hereby authorize that, if necessary, the school nurse and above physician may share information relative to the health of my child.

Signature of Parent/Guardian: _____ **Date:** _____

1528 Elm Street • Manchester, New Hampshire 03101 • (603) 624-6466
Administrative Fax: (603) 624-6584 • Community Health Fax: (603) 665-6894
Environmental Health & School Health Fax: (603) 628-6004
E-mail: health@manchesternh.gov • Website: www.manchesternh.gov/health

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Dear Parent/Guardian:

The Manchester Health Department, along with the School Department recognizes that parents have the primary responsibility for the health of their children. Although it is recommended that medication be given in the home, occasionally it is necessary that medication be given during school hours. Please confer with your child's physician to arrange medication time intervals to avoid school hours whenever possible. However, in the event that medication must be taken in school certain procedures must be followed:

1. A medication form (attached) must be signed by a physician and parent for any and all medications, both prescription and non-prescription (over the counter).

2. One month's supply of medication should be delivered to the school nurse, principal or principal's designee by the parent/guardian or responsible adult.

3. All medication must be in the original container, labeled with the student's name, dose and time to be given.

4. Medication will be administered by the school nurse, principal, or principal's designee.

5. Self-medication of any kind is discouraged and will be considered the responsibility of the parent. Parents of children who require medication should consult first with the school nurse to develop an appropriate plan for medication administration. In some circumstances, school administrators may require that parents administer medication.

6. Long-term medication will be periodically reviewed by the school nurse in cooperation with the parent and prescribing physician and medication orders will be renewed annually.

If you have any questions or concern, please call your school nurse.

School: _____

School Nurse: _____

Address: _____

Phone: _____ **Fax:** _____

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